Utilization Sobriety:  
Brief, Individualized Substance Abuse Treatment  
Employing Ideomotor Questioning  

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This article presents a substance abuse treatment method that acknowledges and accommodates the personal needs that are being addressed by substance. This method, Utilization Sobriety, bypasses perceived resistances and employs idiosyncratic psychobiological learning to achieve a body-mind gestalt that is complementary to the client’s sobriety. It develops a safe framework for addressing any subsequent mental health themes directly or indirectly related to substance misuse. A treatment protocol for the use of Utilization Sobriety as well as relevant clinical material illustrating its application and a discussion of its implications are offered.

**Key words:** Alcohol, benefit state tool, drugs, gestalt, hypnosis, ideomotor, sobriety, utilization, substance abuse

The efficacy of hypnotic approaches to substance abuse treatment is both supported and challenged in the literature. Stoil (1989) notes the many confounding factors involved in accurately evaluating the usefulness of hypnosis in treating alcoholism and the difficulty distinguishing hypnosis from the therapies to which it is applied. Some position hypnotic methods for substance abuse treatment as uneventful, poorly defined, or ill advised because there is a lack of conclusive evidence to justify its application (Nash, 2001; Wadden & Penrod, 1981; Edwards, 1966). Those with successful outcomes, however, cite both the use of hypnosis as the sole treatment (Page & Handley, 1993) and also that of hypnosis used in conjunction with other treatment methods (Orman, 1991; Vandamme, 1986).

The approach this author calls *Utilization Sobriety* poses a commonsense way to work with people to change their substance use habits. By acknowledging, respecting and utilizing the gestalt an individual brings to treatment, the process is kept simple and very idiosyncratic. Treatment can then be responsive to a myriad of
possible causal factors. Utilization Sobriety is a substance abuse treatment approach that employs conscious and unconscious communication which utilizes the individual’s psychobiological learning about a particular substance for the achievement and maintenance of sobriety.

The hypnotic method known as ideomotor (idea/thought + movement) questioning is employed in the Utilization Sobriety approach. It is usually thought of as a way of communicating with deeper levels of mind that are commonly referred to as “unconscious”. Development of “yes” and “no” finger signals, independent of conscious volition, can occur quickly and allows for the elicitation of deeper, less conscious responses. Ideomotor signaling occurs as a commonly observed phenomenon known as body language. During treatment questioning, naturally occurring responses such as a head nod may take place simultaneous with developed finger signals. Erickson (Erickson, Rossi, & Rossi, 1976) commonly worked with a client’s ideomotor expressions and solicited responses via physical movements. Others have elaborated on the development of specific ideomotor signals and approaches to questioning unconscious process (Cheek & LeCron, 1968; Cheek, 1994; Rossi & Cheek, 1988; Rossi, 1986).

No formal trance induction is needed in the Utilization Sobriety procedure. Although the development of ideomotor finger signals may produce various levels of trance, it is only the establishment of the signals that is necessary for the treatment to be engaged. Questions are posed in a way that allows the subject’s idiosyncratic needs to determine the development and depth of trance. The following treatment protocol outlines the initial phase of Utilization Sobriety treatment.

The Utilization Sobriety Protocol

The Utilization Sobriety protocol calls for ample client preparation for hypnotic work and the establishment of good rapport. This may involve providing information about unconscious process and functioning, referencing enhanced client control as inner resources are accessed, eliciting the client’s picture of a goal achieved, and discussing possible awkwardness adjusting to the change. Once adequate preparation has taken place, subsequent steps can follow. They are:

2. Elicit and note words that describe any perceived benefit (emotional, intellectual, sensory, perceptual, behavioral, social etc.) of substance use for the client. This provides information about needs and coping strategies without inducing shame.
3. Ask the client “If it were possible, would you like to be able to experience the same benefits you derive from using X (the substance[s] in question) without actually using X?” If the response is affirmative, then provide more information about the unconscious access to stored memory of experience (behavioral, emotional, physiological etc.). Explain how the physiological system learned all about X after its first usage and encoded that information in the central nervous system as well as how learning can be retrieved and employed.
4. Suggest accessing useful learning by opening a simple channel to the unconscious. Explain how ideomotor finger signals (Cheek & LeCron 1968; Cheek, 1994; Rossi & Cheek, 1988) work and how the client will remain in full control as help is obtained.
from the unconscious resources.

5. Develop “yes” and “no” ideomotor finger signals as described by Cheek (1994).

6. Help the client retrieve the best parts of the substance use state via ideomotor questioning and verification. Asking “Is it alright at this time to call up the very best aspects of X use that you described to me earlier? (review terms client used to describe benefits).” If the “yes” finger lifts, ask, “Will you now develop that experience?” If the “yes” finger lifts, encourage client to tell you when he or she feels the change. If the “no” finger lifts, investigate higher priorities or obstacles via ideomotor questioning.

7. While the client is experiencing the “benefit” state, develop a physical signal (hereafter called the benefit state tool or BST) that client can use at will to call up this state. Anchor the experience to two fingers touching, the squeeze of an ear lobe, or some other cue. Secure ideomotor confirmation that the anchoring signal will retrieve the “benefit” state. Suggest that the client can access this state by putting in a request for the benefit state to the unconscious and employing the physical signal. Elaborate on how the BST is there to use any time, any place. Test the signal before the session ends. Encourage practice using the benefit state tool any time the client is tempted to use the actual substance or involved in stressful circumstances.

8. Inform the client of the significant adjustment involved in changing any relationship. Since the client’s relationship with the substance of choice is changing, the client is asked to write a goodbye letter to this relationship. The letter should be complete in addressing all significant elements of the relationship (i.e. the purpose it served, benefits and detriments, associations with the substance, learning, influences etc.) and the anticipated components of grief. Client is encouraged to keep a journal about changes and to focus on self-care as it relates to exercise, nutrition, social involvement and rest.

9. When working with those previously involved in substance abuse treatment programs or 12 step programs, it is sometimes prudent to avoid language that may associate the benefit/substance-state with the substance. Cognitive congruence may be maintained by presenting the benefit-state as a natural, healthy realization of potentials that were present prior to substance involvement.

Subsequent sessions may focus on reinforcing client gains, relapse prevention, addressing other mental health needs or whatever is idiosyncratically most relevant to the client’s concerns. The following cases provide a variety of circumstances in which Utilization Sobriety was applied.

Case Example I

Lou called my office in desperation and said he was obsessing about heroin and that he was afraid he couldn’t resist it without some help. He wanted to know if hypnosis might help. Lou was seen that afternoon.

Lou was a 30-year-old self-employed craftsman and single parent. He had been smoking heroin for a number of months, and he had convinced himself that he could stop any time he chose. Lou had experienced many other drugs in the past. He said he had been clean for at least a week and realized he could easily “flush life down the drain” if he resumed using. Lou had no history of substance abuse treatment.
Information was gathered about the best parts of the heroin experience and the needs it addressed. After Lou was informed about the nature of hypnosis, I reminded Lou of the physiological learning he already had acquired on a number levels about heroin and many other state-bound experiences. I then asked Lou “if it were possible to experience the best qualities of the heroin use without the actual drug, would you be interested?” Lou said yes. Then I helped him to develop “yes” and “no” ideomotor finger signals.

Following this, I asked the question, “is it alright to call up the best aspects of a very good heroin experience at this time?” The “yes” finger lifted and I suggested Lou just enjoy employing his learning and tell me when he had the best of heroin experience. Within a few minutes Lou became flush and said, “this is really good shit”. I then asked Lou to touch two fingers together on his non-signaling hand and he did this. Ideomotor confirmation was secured that those two fingers touching would be a physical signal Lou could use at will to call up this same “high”.

Lou’s experience deepened as I spoke metaphorically of “driving across state lines” and offered ego-strengthening suggestions (Stanton, 1979, 1989; McNeal & Frederick, 1993; Hartland, 1965). As I posed the possibility of his unconscious helping him in various ways to remain free of the urge to use heroin, his “yes” finger lifted in affirmation. Lou was then encouraged to write a goodbye letter to his relationship with heroin.

The second session we scheduled was cancelled by Lou and never rescheduled. I spoke with Lou by phone a month later and he indicated he had remained clean and was using his “best of” tool often and effectively. A year after the session Lou said, by phone, that he wasn’t finding as much need to use his “best of” tool as his life seemed to be going well. He had remained free of heroin since our session.

**Case Example II**

Sam met with me a week after spending three months in jail. Having begun drinking alcohol and smoking marijuana as a teenager, Sam had a long history of consistent alcohol involvement, bar fights, and outlaw associations. This forty-five-year-old, married, small business owner realized that most of the problem areas in his life were associated with alcohol. He had been abstinent from alcohol for three months and sought help to maintain his sobriety. The last marijuana use by this client was reported to be five months prior to our first meeting. Sam defined marijuana smoking as his “anger management program”.

I gathered much information from Sam about his substance use, the perceived benefits of alcohol use and his history. No prior mental health or substance abuse treatment was reported. Additional motivation for sobriety came from Sam’s probation officer who demanded frequent urinalysis to test for drug use.

After providing Sam with information about hypnosis and elaborating with him about the learning already stored in his system, I asked him if he would like to employ his learning to support sobriety. He quickly asserted an affirmation. Since Sam had sought out hypnosis as a medium for change, he was readily responsive to learning how to develop ideomotor finger signals.

Once the signals were established, I asked Sam “would it be alright to call up the very best aspects of drinking alcohol at this time?... calling up the confidence,
freedom from that self-consciousness and self-criticism… not taking things so personally, a good, warm feeling inside…” (all benefits Sam reported). Sam’s “yes” finger lifted. A few minutes later, he spoke of the warm feeling in his throat and stomach, “just like after having a shot” (of whiskey), and a “clear comfort” with himself, and “a smooth rush”. Sam developed a physical trigger to call up the best of the alcohol experience and was instructed to express his intention internally as he triggered the desired state.

Sam extended treatment another six sessions to address past trauma, unresolved emotional experiences and his current circumstances. Significant progress was made and Sam adapted his BST to all stressful situations successfully. He has remained free of any need to drink or smoke marijuana for one year.

Case Example III

Ed presented as a single, forty-year-old trade apprentice with a dependency on cocaine. He snorted the drug or smoked crack cocaine three to five times a week. In spite of two prior episodes of inpatient substance abuse treatment, Ed reported six months as his longest period of abstinence from cocaine over the past nineteen years. Ed had not responded well to conventional drug treatment and likened using cocaine to “a bad love affair”. Ed recognized he needed help to break his addictive pattern and had received an ultimatum from his girlfriend concerning this matter.

I gathered information about Ed’s current circumstances and history of substance use. Recreation for Ed always involved high-risk adventure sports. I informed Ed about hypnosis and spoke to the learning he had within him about cocaine. Ed was asked about the best aspects of cocaine use and the benefits he derived from it. When asked, he agreed he would like to experience the best parts of cocaine without using the drug.

After Ed developed “yes” and “no” ideomotor finger signals, I solicited the best aspects of the cocaine use experience and a “yes” finger lifted. Another finger signal indicated the experience was engaged. Then, as I asked Ed to touch the thumb and index fingers together on the non-signaling hand, the experience was anchored in that position and called “the best of cocaine tool”. Ed was instructed to combine a request for the best of cocaine with the two fingers touching to get the desired effect.

The second session occurred a week later. Ed expressed delight at having no desire to use cocaine and feeling better in general. He reported using his “best of cocaine tool” often and successfully. During this session Ed referenced unresolved historic themes and an interest in change. We employed ideomotor questioning in an attempt to clear some past emotion using the Goldfinger approach (Walsh, 1997).

At the third session Ed reported having a relapse with cocaine use a week after the second session. He attributed the stress of very long workdays to his stopping one day at his “supplier’s place”. Relapse was normalized as a part of recovery. Relapse prevention strategies were discussed and rehearsed. More unresolved emotion from the past was identified and resolved using ideomotor questioning.

Another week passed before Ed came in for a fourth session. He said he fooled himself into thinking he could do “just one line” and then follow through with his responsibilities. A relapse occurred, and Ed neglected his duties. We reviewed relapse prevention strategies and Ed’s choices. Ideomotor questioning revealed an aspect of Ed that needed to use cocaine as “the ultimate escape” with a sense of “having
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everything”. Much negotiation took place with this part of Ed before securing ideomotor confirmation that Ed could remain free of any desire to use cocaine.

Six months later Ed called for an appointment. He reported doing very well until recently when his girlfriend was gone for a three-week trip. He did not use his “best of tool” during the girlfriend’s absence and realized that his drug use might end the relationship. We explored some of Ed’s needs, self-perception and patterns of self-sabotage. More negotiation took place regarding Ed recognizing his choices and choosing what is truly in his best interest and compatible with his goals. Ed did not schedule another appointment.

Almost two years later I spoke with Ed. He explained that he had finally figured out how to use his “tool” in the right way and had stayed clean over the past year and a half. When questioned further Ed explained how he had recognized the damage he had done to relationships in his life and “figuring out how to use his tool” was really about “deciding” to use his tool. He also explained that he changed his work location and crew. This gave him more distance from a coworker who also used cocaine and from his cocaine supplier. Ed reflected how he finally followed through with the relapse prevention strategies we had discussed after numerous relapses. He said he wasn’t using his “tool” as much because he was doing quite well. Now free of any inclination to use cocaine and doing well personally and occupationally, Ed expressed remorse for the pain he caused others during his years of drug use.

Discussion

The Utilization Sobriety model simply utilizes what already exists within the person who is seeking help. Treatment employs both psychobiological processes and learning, enculturated themes about substance use, and idiosyncratic response to needs. Utilization Sobriety provides a quick and painless avenue for withdrawal from a substance while honoring adaptive strategies for living, surviving, coping and healing. The goal in developing the BST is both for relapse prevention and the bridging of prior coping strategies with new perspective. Using the BST is about developing a new habit and recognizing choices involving an inner locus of control. Exercising choice then becomes an important focus of therapeutic communications as the treatment goal is achieved or refined.

As ideomotor signals are developed and the substance experience is called up, the anxiety often present at the onset of treatment is typically quelled. For some, substance use began as a means to calm anxiety symptoms. The BST allows the client the same calming benefit with rapid response.

Is the BST providing the same exact experience as the actual substance used by the client? As illustrated in the case examples, some aspects of the solicited endogenous experience may be quite similar to the effects of actual substance. Other components of the BST will be perceived differently. Essential to this approach is trusting the individual’s unconscious process to deliver the best elements of the substance using experience, as idiosyncratically meets the client’s needs.

Ideomotor questioning provides a convenient means of accessing and utilizing sensory, emotional, cognitive and physiological learning without needing to navigate through perceptual limitations. During the Utilization Sobriety procedure, ideomotor facility allows for a seamless transition to treatment of co-morbid themes which may be
contributing or precipitating factors of substance use (Cheek, 1994; Cheek & LeCron, 1968; Rossi, 1986; Walsh, 1997). Ideomotor questioning can provide information that is helpful in identifying therapeutic priorities and direction, regardless of what treatment approach is subsequently applied.

Information held as an implicit (non-narrative) memory or state-bound in some biochemical matrix is often accessible via ideomotor questioning (Overton, 1972, 1973; Rossi, 1993; Brown, Schefflin & Hammond, 1998; Cheek, 1994). Cheek (1994) suggests ideomotor questioning is a way to communicate at a physiological level, bypassing cognition all together. It is the author’s opinion that the experience of putting any mood or mind altering substance into the body produces a peculiar physiological state, binds at least some information to the state, and goes far beyond what can be explained through cognitive means by the altered individual. Requesting the desirable aspects of a substance-state via ideomotor questioning likely accesses both the implicit (behavioral, sensory) and explicit, narrative memory systems (Pillemer & White, 1989). Constructing a new perspective and context for the substance experience may catalyze other changes in cognition and physiology.

How much control can one exert on biochemistry and physiology without using various substances? Anecdotal reports and empirical evidence cited by Weil (1995), Siegel (1988), Benson (1996) and Simonton (1978) tout the great influence of thought, perception and emotion upon physiology and health. The process of employing the perceptual elements of a client’s past learning that is related to substance use may indeed elicit a particular physiological shift. A physiological shift may generate emotional, perceptual and even behavioral changes. Although what is happening at a physiological level with clients when they use the BST is currently unknown, their testimonials reflect an experiential shift that is often objectively observable. Access to the body-mind gestalt that ideomotor questioning and signaling seems to provide offers much encouragement for ongoing exploration of its various therapeutic applications. It is possible that in the future research might be able to cast light upon the neurophysiologic mechanisms of this method.

References


